

CITY OF LINCOLN/LANCASTER COUNTY
EMPLOYEE CONSENT FOR HBV, HCV AND HIV TESTING FOLLOWING A
SIGNIFICANT EXPOSURE TO BLOOD OR OTHER POTENTIALLY INFECTIOUS
MATERIALS AND RELEASE OF INFORMATION

As an employee of the City of Lincoln/Lancaster County, this will confirm that I have communicated with medical care providers who believe I have had a significant exposure to blood, or other potentially infectious materials, in the course of my job duties.

I therefore voluntarily give permission for a sample of my blood to be drawn and test for:
Initial next to each test to be performed:

_____ Hepatitis B antibody (**Do Not** initial if you were tested in the past and found to have immunity to Hepatitis B.)

_____ HIV antibody (Human Immunodeficiency Virus)

_____ Hepatitis C antibody (**Do Not** initial unless source individual has been documented to have Hepatitis C virus infection.)

I understand the provisions of Neb. Rev. Stat. 71-503.01, with respect to confidentiality and/or anonymity will be strictly followed.

I also understand that state law (Neb. Rev. Stat. 71-503.01, Cum. Supp 1994) requires that if these test results, in combination with other data. Leads the medical consultant or my physician to make a diagnosis of HIV, HBV or HCV infection, that my case must be reported to the Nebraska Health and Human Services Communicable Disease Program.

I have been informed that if either of the HIV, HBV, or HCV is positive, a physician will provide counseling for follow-up care and for precautions against transmitting these infections.

I understand that if I refuse, my exposure to HIV, HBV, or HCV will remain unknown. My ability to infect others with these viruses will also remain unknown.

I have been advised about the nature of the HIV, HBV and HCV tests, their expected benefits and risks and have been given an opportunity to ask questions. I freely give my informed consent and have not been subjected to any constraint or inducement. I understand that I may withdraw this consent anytime prior to having my blood drawn.

I also consent to allow the Lincoln-Lancaster County Health Department, access to my test results to provide me with information and counseling regarding my condition.

Employee Signature

Social Security #

Date